Washington State Department of Health

Tuberculosis Contact Investigation Form

Case Information

3 copies: PRESS HARD

Case Name _____ County_____ If private case, provider name/phone _____

Date of Birth_____ Disease Site and Date_____ Sputum Smear Result _____ Culture Result _____

Drug Resistance_____

Medical Record No._____

For State Use Only: State Case No. _____Morbidity Date _____

Contact Information

Contact Information: Last name, First name, Relationship (wife, coworker, etc.), Other relevant information	DOB	Sex	Contact Type or # 1=close 2=casual	Documented Prior + PPD	Initial PPD Date Read & Result (mm)	90 DAY PPD Date Read & Result (mm)	X-RAY Date & Result	PREVENTIVE TREATMENT (List drugs) Date Begun	Date Completed	**If treatment not completed, please list reason**: death, moved (no follow-up info), active TB developed, adverse effect of Rx, contact chose to stop, lost to follow-up, provider decision.
_____ _____ _____ _____				Date: mm:						
_____ _____ _____ _____				Date: mm:						
_____ _____ _____ _____				Date: mm:						
_____ _____ _____ _____				Date: mm:						

WHEN THE FOLLOWING RESULTS ARE AVAILABLE, PLEASE SEND THE APPROPRIATE COPY TO THE STATE TB PROGRAM: (1) Goldenrod copy with results of initial PPD, X-rays, and medication start dates within 30 days of beginning investigation. (2) Pink copy with results of 90 day PPD, x-ray and therapy start date. (3) Yellow copy with final preventive treatment information. (4) White copy to remain in the county health department patient record.